Investigative Report

On-Site Federal Hospital Investigation

Facility: Smokey Point Behavioral Hospital
Location: Marysville, WA
License Number: HPSY.FS.60739147
Medicare Number:
State Case Number: 2018-11389
Complaint #: 83582
Shell #: UOE811
Dates of Investigation: 8/22/2018
Investigator: Surveyor #27347

Allegations—the complainant alleges:

1. Patient's schizophrenia not properly treated. Medications not given as ordered. Patient as result of this would not eat believing voices telling her not to eat. Patient fell and sustained several fractures. Transferred to hospital on 6/29/18 and passed away on 7/20/18 due to malnutrition/failure to thrive as primary causes of death.
   a) CEO (chief Executive officer) admitted patient over objections from medical director to admit-hospice care not arranged for patient

2. Patient under ITA (Involuntary treatment act) hold from June 1st-August 2nd-discharged with no appropriate plan in place for him to succeed in the community-patient was still expressing suicidal ideations with plan to kill himself on August 1, 2018 and he was still discharged on August 2, 2018.

3. Patient admitted from Dec 3, 2017 to February 5, 2018-taken to Providence Everett about wound on his foot that deteriorated and was found to have sepsis-**this was addressed March 2018 survey.**

Process: The investigative process included the following:
Talked to the medical examiner office
Talked to the complainant
Reviewed the patient's medical record
Interviewed direct care and administrative staff
Reviewed policies and procedures
Reviewed the discharge process for patients

Summary of Findings:

1. The patient was admitted to the behavioral health hospital on 3/22/18 after not eating well at her home. During the patient's stay at the behavioral health hospital the patient did not consistently eat or drink well. The behavioral health hospital would give the patient their medications by injection when the patient refused to take them orally. The patient was sent to the local acute care hospital emergency room on three occasions due abnormal lab results and on two occasion due to the patient's poor oral intake.
The patient was sent to the local acute care hospital emergency room on 6/16/18 after a fall it was discovered the patient had fractured their proximal humerus (arm) no other fractures were identified. The patient was not a candidate for surgery and was treated with an arm sling.
The patient was sent by the behavioral health hospital on 6/29/18 to the local acute care hospital after the patient became lethargic and was not responding to staff. The behavioral health notes on 6/29/2018 stated the patient had not eaten or drank anything for the last 4 days. The patient did not return to the behavioral health hospital. The patient passed away at the local acute care hospital on 7/20/18.
The medical examiner report revealed "manner of death accident; cause malnutrition and failure to thrive due to decompensated schizoaffective disorder with psychosis. Contributing factors: right hip fracture, right humerus fracture and congestive heart failure.

There was no evidence that the CEO admitted the patient over the medical director. There was documentation that the CEO was informed when with the psychiatric physician sent the patient to the hospital on 6/29/2018. The medical physician was not included in the decision of whether the patient was still appropriate for continued admission in the hospital.
2. The patient was assessed for suicidal ideations on the day they were discharged back to their community on 8/2/2018. The risk was felt to be low and the patient was discharged with follow-up appointments for mental health care in place. On the day of discharge the patient voiced no objections to being discharged.
3. The facility was cited for this issue by the Department of Health during their March 2018 survey. The facility was in their plan of correction phase to address the systems that contributed to the issues.

Conclusion: The behavioral health hospital was cited for not coordinating the care of the patient with the medical doctor and for not following their policy to discharge patients that required nursing home level of care.

Action: Statement of deficiency written for: Violations of 246-322 WAC Private Psychiatric and Alcoholism Hospitals.-State
Violation of 42 CFR 482 for Care of patients. Responsibility of care.-Federal

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Redaction Summary (0 redactions)

0 Privilege / Exemption reason used:

Redacted pages: